Your Dentacare Benefits

Schedule of Dental Services and Supplemental Charges – State of Indiana

Subscriber and eligible dependents shall be provided with, subject to the limitations and exclusions and any annual fee-for-service maximum, the following services at no expense except for the copayments set forth below. The copayments shown are fixed and predetermined to be below the dentist's usual and customary fee. An annual fee-for-service maximum as set forth below, exclusive of orthodontics, shall apply per subscriber, spouse or dependent.

Benefits covered under this plan will be provided at the dental center in which the member is enrolled, or by prior written authorization from the administrator for this plan. Your Dentacare benefits are offered by Anthem Health of Indiana, Inc.

Annual Maximum: $1,000

DENTAL SERVICES AND SUPPLEMENTAL CHARGES		
0999	Office visit	$5.00

Diagnostic

Includes the necessary procedures which will aid the dentist to evaluate existing conditions and determine what dental care is required, including: examinations, visits and consultations; X-rays, full mouth X-rays at 12 month intervals if necessary; Bitewing X-rays at 6 month intervals if necessary; other X-rays as required.

ADA CODE		PATIENT COPAYMENT
0110	Initial oral exam	No Charge
0120	Periodic oral exam	No Charge
0130	Emergency oral exam	No Charge
0210	Intraoral radiographs - complete series (including bite-wings)	No Charge
0220	Intraoral periapical radiograph - first film	No Charge
0230	Intraoral periapical radiograph - each additional film	No Charge
0240	Intraoral occlusal radiograph	No Charge
0270	Bite-wings radiograph - one film	No Charge
0272	Bite-wings radiograph - two films	No Charge
0273	Bite-wings radiograph - three films	No Charge
0274	Bite-wings radiograph - four films	No Charge
0330	Panographic film	No Charge
0460	Pulp vitality test	No Charge
0470	Diagnostic casts	No Charge

DENTAL SERVICES AND SUPPLEMENTAL CHARGES

Preventive

Includes those necessary procedures which prevent oral disease from occurring, including (but not limited to): prophylaxis - cleaning, polishing, and scaling teeth at 6 month intervals; topical fluoride applications for eligible dependents under age 19 at 12 month intervals; space maintainers - temporary space maintenance for children until permanent teeth erupt to prevent unnecessary orthodontic expense.

ADA CODE		PATIENT COPAYMENT
1110	Prophylaxis (adult) - limited to two per year	No Charge
1120	Prophylaxis (child) two per year unless prescribed more frequently - limited to two per year	No Charge
1201	Topical application of fluoride including prophylaxis (individual to age 19) - limited to to per year between 1120-1201	No Charge
1203	Topical application of fluoride excluding prophylaxis (individual to age 19) - limited to two per year	No Charge
1310, 1330	Dietary planning, Oral hygiene instruction	No Charge
1351	Sealant application	See Restorative
1510-1525	Space maintainers	See Prosthetics
9110	Emergency palliative treatment	No Charge

Restorative

Includes all necessary procedures for: amalgam, synthetic porcelain, plastic and composite restorations; metal restorations when teeth cannot be restored with another filing material; indirect pulp capping, bases, liners, and acid etch procedures.

1351	Sealant application - per tooth (individual to age 19)	$6.00
2110	Amalgam - one surface primary	$8.00
2120	Amalgam - two surface primary	$11.00
2130	Amalgam - three surface primary	$12.00
2131	Amalgam - four surface primary	$14.00
2140	Amalgam - one surface permanent	$9.00
2150	Amalgam - two surface permanent	$12.00
2160	Amalgam - three surface permanent	$14.00
2161	Amalgam - four surface permanent	$17.00
2330	Resin - one surface anterior including acid etch	$11.00
2331	Resin - two surface anterior including acid etch	$14.00
2332	Resin - three surface anterior including acid etch	$19.00
2335	Resin - four or more surface involving incisal angle - including acid etch	$22.00
2940	Filling - sedative	$9.00
2950	Crown buildup	See Prosthodontics
2951	Pin retention (per tooth) -- in addition to restoration	$12.00

DENTAL SERVICES AND SUPPLEMENTAL CHARGES

Oral Surgery

Includes necessary procedures for simple extractions and other routine dental surgery not requiring hospital admission. Includes pre- and post-operative care, evaluation, and treatment under local anesthetic.

Minor Oral Surgery (General Dentistry)

ADA CODE		PATIENT COPAYMENT
7110, 7120	Routine extraction single tooth, each additional tooth	No Charge
7310	Alveoloplasty - conjunction w/extractions-per quadrant	No Charge
7130	Root removal - exposed roots	No Charge

Major Oral Surgery (Specialty)

7999	Specialist consultation and diagnostics	$14.00
7210	Surgical removal of erupted tooth	$21.00
7220	Surgical removal of tooth (soft tissue impaction)	$25.00
7230	Surgical removal of tooth (partial bony impaction)	$35.00
7240	Surgical removal of tooth (complete bony impaction)	$45.00
7280	Surgical exposure of impacted or unerupted tooth for orthodontic purposes (not including orthodontic attachments)	$45.00
7281	Surgical exposure of impacted or unerupted tooth to aid eruption	$40.00
7320	Alveoloplasty conjunction - w/o extractions (per quadrant)	$35.00
7510	Incision and drainage of abscess (intraoral soft tissue)	$8.00
7960	Frenectomy	$25.00
7970	Excision of hyperplastic tissue (per arch)	$17.00

Periodontics

Includes necessary procedures for providing treatment of disease of gums and bones supporting the teeth, not requiring hospitalization. Includes pre- and post-operative evaluations and treatment under local anesthetic.

Minor Periodontics (General Dentist/Specialty)

4341	Scaling and root planning-per quadrant w/local anesthesia - limited to 4 quadrants per year	$20.00
4345	Scaling performed in the presence of gingival inflammation - full mouth - limited to one per year	$20.00

Major Periodontics (Specialty)

4999	Specialist comprehensive period exam and evaluation	$14.00
4210	Gingivectomy or gingivoplasty (per quadrant)	$75.00
4240	Gingival flap procedure including root planing (per quadrant)	$85.00
4260	Osseous surgery, flap entry & closure (per quadrant)	$100.00
4270	Pedicle stop tissue graft (includes coronally and double papilla positioned flaps) (per quadrant)	$65.00
4272	Apically repositioned flap (per quadrant)	$65.00
7960	Frenectomy (covered at Oral Surgery benefit level)	$25.00
4330	Occlusal adjustment (limited)	$6.00
4331	Occlusal adjustment (complete) per appointment	$22.00

DENTAL SERVICES AND SUPPLEMENTAL CHARGES

Prosthetics*

Includes necessary procedures for providing artificial replacements for missing natural teeth. Construction, placement and insertion of bridges, partial and complete dentures; relining and repair of bridges, partial and complete dentures; space maintainers; inlays; crowns.

ADA CODE		PATIENT COPAYMENT
1510-1525	Space maintainers (primary tooth stage)	Lab Fee Only
2510	Inlay-metallic one surface	$85.00
2520	Inlay-metallic two surface	$95.00
2530	Inlay-metallic three surface	$100.00
2540	Onlay-metallic	$100.00
2740	Crown - porcelain/ceramic substrate	$95.00
2750-2752	Crown - porcelain fused to non-precious metal	$95.00
2790-2792	Crown - full cast non-precious metal	$95.00
2810	Crown - 3/4 cast non-precious metal	$100.00
2910	Recement inlay	$8.00
2920	Recement crown	$8.00
2930	Crown-prefabricated stainless steel (primary)	$22.00
2950	Crown buildup (restorative material and any pins)	$22.00
2952	Cast post and core (including canal preparation)	$35.00
2954	Pre-fabricated post with core buildup (includes canal preparation, restorative material and any pins)	$30.00
2970	Crown - temporary for fractured tooth only	$20.00
2970	Crown - temporary in conjunction with permanent crown	No Charge
5110-5120	Denture - complete upper or lower	$125.00
5130-5140	Denture - immediate upper or lower	See Limitations
5213-5214	Denture - upper or lower partial with metal lingual or palatal bar, clasps and acrylic saddles and acrylic base or cast metal framework	$145.00
5410-5422	Denture adjustment (no charge if within 6 month of initial placement)	$4.00
5510, 5520	Denture repair - chairside (per repair)	$10.00
5610-5640	Denture repair - chairside (per repair)	$15.00
5510, 5520	Denture repair - laboratory repair	Lab Fee Only
5610-5640	Denture repair - laboratory repair	Lab Fee Only
5730-5741	Denture reline/rebase-chairside	$35.00
5750-5761	Denture reline/rebase-laboratory	Lab Fee Only
5860-5861	Overdenture	See Limitations
6210-6212	Bridge pontic - non-precious metal	$100.00
6240-6242	Bridge pontic-porcelain fused to non-precious metal	$100.00

DENTAL SERVICES AND SUPPLEMENTAL CHARGES

Prosthetics*

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ADA CODE		PATIENT COPAYMENT
6520	Bridge retainer-inlay-metallic two surface	$65.00
6530	Bridge retainer-inlay-metallic three surface	$75.00
6540	Bridge retainer-onlay-metallic	$95.00
6545	Cast metal retainer for acid etch bridge w/initial bonding pontics at 6210-6212 or 6240-6242 copay	$55.00
6750-6752	Bridge retainer-crown-porcelain/non-precious metal	$90.00
6790-6792	Bridge retainer-crown-full cast non-precious metal	$90.00
6930	Recement bridge	$11.00
6970-6971	Cast post and core (includes canal preparation)	$35.00
6972	Prefabricated post with core buildup (including canal preparation, restorative material and any pins)	$35.00

** Precious and semi-precious metals, if used, will be charged to the patient at the additional cost of the metal. This applies to inlays, crowns, bridges and cast post & cores.*

Endodontics

Includes necessary procedures for treatment of disease of the pulp chamber and pulp canals, not requiring hospitalization. Pulpal therapy and root canal filing; pulpotomy; pulp capping.

3999	Specialist consultation and diagnostics	No Charge
3110	Pulp capping (direct)	No Charge
3120	Pulp capping (indirect)	No Charge
3220	Pulpectomy (excluding final restoration)	No Charge
3310	Root canal therapy - one canal	No Charge
3320	Root canal therapy - two canals	No Charge
3330	Root canal therapy - three canals	No Charge
3340	Root canal therapy - four canals	No Charge
3410, 3411	Apicoectomy (per tooth, per root)	No Charge
3430	Retrograde filling (per tooth, per root)	No Charge
3440	Apical curettage (in conjunction with apicoectomy)	No Charge

Anesthesia

9211	Regional block anesthesia	No Charge
9212	Trigeminal division block anesthesia	No Charge
9215	Local anesthesia	No Charge

Failed Appointments

0016	Without 24 hour prior notification (Dentist charges for failed appointments will be the full responsibility of the patient.)	

DENTAL SERVICES AND SUPPLEMENTAL CHARGES

Out of Area Emergency Treatment

If outside the geographical area of the designated dental group office (more than a 50 miles radius), eligible covered person will be directly reimbursed for emergency treatment to a maximum of $50.00. Emergency treatment refers only to those dental services required to alleviate pain and suffering.

Accidental Injury

There is no coverage for accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.

Orthodontics

50% benefit to a lifetime maximum payment of $750.00, which is separate from the annual $1,000.00 maximum for all other services.

50% patient benefit is applicable towards consultations, records, fees, treatment, and retention.

Orthodontic treatment to correct malocclusion is limited to one course of Phase II Permanent Dentition treatment and retention. This would include office records, comprehensive full banding and/or bonding of the permanent dentition, the initial retention appliances and office visits for retention. Total coverage period for treatment and retention will be a maximum of 24 months. There will be no benefits paid for treatment or retention beyond the 24 month period. Determination of such expense for treatment and retention will be the responsibility of the subscriber and the treating dentist.

The 24 month period shall be defined as that 24 month period commencing with the initial banding and/or bonding of the case, as reported by the treating dentist, and extending up to and including that date 24 months later.

Covered services include, but are not limited to cephalometric film, post treatment stabilization. Orthognathic surgery is excluded from this benefit.

Services covered within the 24 month period are:

0340	Cephalometric film (included in office records)	No Charge
8560-8580	Class I, II, and III (Orthognathic Surgery Excluded)	
8750	Post treatment stabilization	